Pennsylvania MEDICAL SOCIETY®

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September 10, 2018

The Honorable Seema Verma, Administrator
Centers for Medicare and Medicaid Services
Department of Health and Human Services
Attention: CMS-1693-P
P.O. Box 8016
Baltimore, MD 21244-8016

RE: Medicare Program; Revisions to Payment Policies under the Physician Fee Schedule and Other Revisions to Part B for CY 2019; Medicare Shared Savings Program Requirements; Quality Payment Program; and Medicaid Promoting Interoperability Program (CMS-1693-P)

Dear Administrator Verma,

On behalf of Pennsylvania physicians, the Pennsylvania Medical Society (PAMED) in concordance with the undersigned organizations is writing to comment on the Medicare Program; Revisions to Payment Policies under the Physician Fee Schedule and Other Revisions to Part B for CY 2019; Medicare Shared Savings Program Requirements; Quality Payment Program; and Medicaid Promoting Interoperability Program proposed rule (CMS-1693-P). We wish to commend the Centers for Medicare and Medicaid Services (CMS) for successful continuation of the Quality Payment Program (QPP). However, we are deeply concerned over the proposed changes regarding the physician fee schedule, and the effects the proposed regulations will have on health care delivery, and the health and welfare of millions of Medicare beneficiaries.

PHYSICIAN FEE SCHEDULE

Evaluation and Management Documentation Guidelines

We welcome and support CMS' Patients Over Paperwork Initiative. Updating and streamlining Evaluation and Management (E&M) documentation guidelines is timely and practical to align with the growing technology currently used in health care.

We advocate for CMS lessening the burden of documentation of medical necessity when providing a home visit. Additionally, we support eliminating the prohibition of same-day E&M visits billed by physicians in the same group or medical specialty.

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Implementation of relaxed documentation requirements for E&M visits would be a welcome improvement in reducing burden for physicians who consistently find that paperwork and documentation demands are decreasing time spent face-to-face caring for patients. However, it is worth noting that the benefit of this proposal to reduce documentation burdens is something that many physicians would value in theory but would not ever be realized. For example:

- Many physicians in Pennsylvania participate with Medicare, commercial, Medicaid, and Medicare Advantage Organization (MAO) plans. Regardless of Medicare's proposal to reduce documentation, physicians will need to continue with the burdensome documentation for their non-Medicare patients. Physicians do not – and should not – consider the payer when documenting history, examination, assessment, and treatment plans in current patient management. Differentiating documentation methods for different payers would not benefit patients or physicians in any regard. Therefore, if Medicare documentation burdens are to be eased, physicians would not be afforded the benefits of reduced documentation requirements because the requirements remain for other payers.

- Value-based contracts in alternative payment models (both risk-based and non-risk-based) with payers across the Commonwealth require extensive documentation of conditions and histories in order for a physician to be appropriately evaluated and compensated. For physicians that are able to take advantage of the reduced documentation requirements, they may be realizing a very short-term benefit in exchange for a long-term loss under a value-based contracting payment program. There is also the increased risk of difficulty in participating in data-driven alternative payment models due to "poor" or "lacking" documentation.

We find it perplexing that CMS acknowledges that, although physician documentation standards would be relaxed, documentation in general would continue in its current state for other reasons, and ultimately not be reduced. "Practitioners could choose to document more information for clinical, legal, operational or other purposes, and we anticipate that for those reasons, they would continue generally to seek to document medical record information that is consistent with the level of care furnished."[1] In the same rule, CMS states "However, we believe that eliminating the distinction in payment between visit levels 2 through 5 will eliminate the need to audit against the visit levels, and therefore, will provide immediate relief from the burden of documentation."[2]

While we recognize CMS' intentions to simplify documentation standards, it seems that there is too much ambiguity in order to resolve these two statements, and for that reason, we are reluctant to support CMS' proposed changes to the documentation standards.

Evaluation and Management Payment Structure

We understand CMS' proposal to simplify billing for physicians; however, we must oppose the proposed collapsing of payment rates for levels 2 through 5 for new and established patients.

Collapsing levels 2 through 5 into a single payment rate would disincentivize physicians to care for patients with more complex or multiple issues, to a point some might consider penalization. The E&M coding collapse undervalues the element of time involved in dealing with the complicated patient in any discipline. The proposal

[1] Medicare Program; Revisions to Payment Policies under the Physician Fee Schedule and Other Revisions to Part B for CY 2019; etc., Page 337

[2] Medicare Program; Revisions to Payment Policies under the Physician Fee Schedule and Other Revisions to Part B for CY 2019; etc., Page 349

is detrimental to physicians in specialties that treat the sickest patients, as well as physicians who provide comprehensive primary care, and ultimately would hurt patients' ability to access care. Furthermore, it would harm patients by disincentivizing physicians who treat multiple, more complex, or time-consuming issues at a given office visit. Implementation of this proposal could pose an increased risk to the most vulnerable beneficiaries.

Additionally, this payment proposal is a disservice to patients. The proposed policy may require physicians to see more patients in a day to achieve the same overhead, which would result in less time available for the doctor and patient to share. The increase in time made available by reducing documentation is offset to a greater degree by the decrease in total time available for patients, which would ultimately harm the doctor-patient relationship.

Alternatives to E&M Payment Structure

The higher level 4 and 5 visits are the most common levels one would code for a patient with an acute unstable problem, and/or high complexity medical decision making. For many physicians, this is where the majority of face-to-face patient time is spent. The current proposal to set it below the current level 4 payment is grossly inadequate. Instead, it would be more reasonable to set a payment level between the current payment for these two codes.

We would recommend the study of alternative proposals, including the following example; similar to the proposed payment structure, collapse billing levels to three options, instead of two, for new patients and for established patients:

1. Level 1 remains unchanged.
2. Calculate a weighted average for payment and RVU for levels 2 and 3, and collapse into a single "moderate" category.
3. Calculate a weighted average for payment and RVU for levels 4 and 5, and collapse into a single "complex" category.

The difference in complexity between levels 2 and 3, and 4 and 5 is much less significant than the range between levels 2 and 5.

Proposed New Codes for Complexity, Primary Care, and Prolonged Services

Overall, we do not support the creation of additional codes and its related increased convolution. Having to create codes to compensate for various types of specialties, patient complexities, and services only highlights the problematic nature of the proposed code structure.

The proposed code for a highly complex patient is designated for only selected specialties. It is quite possible that an unnamed specialty would have a need to bill for services provided to a medically highly complex patient. CMS does not offer a solution for those instances in the proposed rule.

Additionally, for an advanced-trained professional to be reimbursed approximately $67 for 30 minutes of their time for providing Prolonged Services, whose earnings must support the practice overhead, is unrealistic and unacceptable. Such low revenue for a highly skilled professional and the accompanying operating costs would prove difficult, if not impossible, for the practice to remain self-sustaining. Moreover, such low revenue will act as a disincentive to physicians in training who might otherwise choose primary care as their specialty.

Telehealth

We support the proposal to allow billing for virtual check-ins and for remote evaluation of recorded video images. We appreciate that CMS recognizes the expansion of technology in health care and how it brings patients and physicians into 21st-century communication. Utilizing telecommunications would save time and travel expense for patients, increase convenience and access to care, and reduce unnecessary visits. Expanding telehealth in this manner respects the time that physicians spend to manage their patients' conditions and care with their patients after clinic hours.

Discount for Same Day Visit and Procedure

We do not support the proposal which denies appropriate payment for E&M services when billed with Modifier 25 by reducing reimbursement for the lesser of those services by 50 percent. According to Current Procedural Terminology (CPT) guidelines, Modifier 25 is used to indicate a significant, separately identifiable, and medically necessary E&M service provided on the same day as a procedure. Providing medically necessary, separate, and distinct services on the same date of service allows physicians to provide effective and efficient, high-quality care. This can save patients from a return visit, and thus increase patient convenience and satisfaction.

Separate services should be reimbursed appropriately and in accordance with established coding conventions and guidelines, whether used on the same date or different dates. Modifier 25 is specifically indicated for use when distinct E&M services – distinguishable from any E&M work integral to a procedure's valuation – are performed. As such, Modifier 25-specified E&M work is no less than what would be done if the patient were to be evaluated on a separate day. Therefore, it is completely unreasonable to arbitrarily diminish the value of that work by relegating it to a 50 percent payment reduction when it is done on the same day as a procedure. "A professional who continually accepted a 50 percent discount for highly skilled work with complex patients could not financially sustain a practice." [3]

The AMA Relative Value Scale Update Committee (RUC) reviews relative value units (RVU) and updates them to reflect changes in physician work, practice expense, and malpractice inputs. The RUC is now automatically reducing procedure pre-service time estimates and value for all codes typically billed with an E&M visit. Therefore, the value of codes commonly billed with Modifier 25 have already been reduced in RVU to account for the potential overlapping of work performed during an E&M service. Additional reduction in an appropriately billed, separate, and unrelated E&M service is arbitrary, unfair, and without merit. We urge CMS to reconsider this ill-advised proposal.

In the recent past, other insurance companies, specifically Anthem Blue Cross Blue Shield and United Healthcare, have announced and then reversed similar reimbursement policies for procedures rendered on the same day as E&M visits. Upon the payers' realization of a misunderstanding related to use of Modifier 25 and the valuation of procedures impacted by this policy, the payers ultimately recognized the inappropriateness of their position.

We are truly concerned about the unintended consequences of moving forward with the E&M coding changes proposed in this rule. CMS must be made aware that the Medicare Part B fee schedule is the basis of many other fee schedules, with both MAOs and other commercial payers. Changes made to Medicare's E&M payment structure will extend beyond the intended services rendered to Medicare beneficiaries and ultimately affect many other reimbursement schedules, compounding its financial impact to physicians deleteriously.

[3] Berenson, R. A., & Lazaroff, A. (2018, August 15). The False Choice of Burden Reduction Versus Payment Precision In The Physician Fee Schedule [Web log post]. Retrieved August 29, 2018, from www.healthaffairs.org

Furthermore, CMS should be acutely aware of the potential windfall to MAOs. The Milliman's Research Report *State of the 2018 Medicare Advantage Industry: Stable and Growing* states "The MA program continues to be an attractive business opportunity for current and new MAOs." [4] With the evolution of risk management and hierarchical condition category (HCC) coding, the model identifying patients with serious conditions and illnesses and assigning a risk score has already proven notably profitable for MAOs. Rising per member per month capitation rates have been successfully leveraged by MAOs, and in some instances dubiously. In the article, "UnitedHealth Overbilled Medicare by Billions, U.S. Says in Suit" published on May 19, 2017 in the *New York Times*, writer Mary Williams Walsh writes, "The government pays insurers a pre-determined amount for each person they enroll in Medicare Advantage, rather than paying doctors and hospitals a fee for every service provided. And to keep the insurers from enrolling only healthy people, the government agreed to pay them more for unhealthy enrollees. How much more depends on a complex "risk scoring" system, established by Medicare."[5]

If CMS finalizes the E&M payment structure as proposed, MAOs would follow suit with a similar structure, imposing reimbursement cuts for level 4 and 5 visits – services provided to the highly complex patients – all the while simultaneously securing maximum risk-adjusted capitation for themselves. We implore CMS to adequately resolve the skewed and unbalanced structure before implementing such a model.

QUALITY PAYMENT PROGRAM

Performance Category Values

We appreciate the flexibility proposed for future selection and scoring of quality measures. We ask for CMS' consideration of using scoring measures for high weight and medium weight. We believe utilizing consistent language across performance categories would aid in reducing confusion.

We agree clinicians should be able to meet the needs of the program by selecting a combination of measures that meet the needs of their practice without restriction or threshold of measures. We also agree that a clinician should possess the ability to achieve a maximum score without submitting six measures.

Increasing Performance Category Weighting and Performance Thresholds

We agree with the modest increase in the Cost performance category of 5 percent as a result of the Bipartisan Budget Act of 2018. We believe to streamline the measurement process, the alignment of increases or decreases in both performance categories and performance thresholds could alleviate some of the mystery that presents each year surrounding the program. By establishing a consistent increase or decrease, clinicians would have adequate preparation time prior to the beginning of the new performance year.

We suggest that in light of our comments, the 2019 MIPS performance threshold should be increased to 20 points to align with the 5-point increase within the Cost performance category.

Leverage the QPP Portal

We commend CMS for creating a robust and user-friendly portal for the submission of QPP performance data and receipt of performance feedback. The reporting mechanisms are clear, concise, and simple to transmit data.

[4] Friedman, FSA, MAAA, Julia M., and Brett L. Swanson, FSA, MAAA. "State of the 2018 Medicare Advantage Industry: Stable and Growing." Milliman, 28 Feb. 2018.
[5] Williams Walsh, M. (2017). Retrieved from https://www.nytimes.com/2017/05/19/business/dealbook/unitedhealth-sued-medicare-overbilling.html

We propose to unify the reporting and election mechanisms by leveraging the QPP portal to satisfy all needs of the program. This includes:

- Virtual Group Registration
- Sub-group Reporting
- CMS Web Interface Reporting
- Hardship Exemption Applications
- Facility Based Assignments
- Opt-In and Voluntary Reporting
- MIPS, MIPS APM, and Advanced APM Reporting
- CAHPS for MIPS Elections
- Targeted Review

The ability to maintain access to all reporting and elections for the QPP in one place could alleviate participation burden by locating all areas of the program in a "one-stop shop."

Aggregate Sub-group Reporting into the Group Final Score

In response to CMS' proposal for sub-group reporting in Year 4 of the QPP, we support the proposal that sub-groups MIPS performance data should be aggregated with the score of the primary group.

The sub-group should possess an identifier that ultimately links the group back to the primary practice via the Tax Identification Number (TIN).

Clearly Define Promoting Interoperability - Query of Prescription Drug Monitoring Program Requirements

We would like to express concern regarding the proposed Promoting Interoperability measure, Query of the Prescription Monitoring Program. Although we support offering a bonus score for the submission of one patient, it is imperative that, if the measure becomes a requirement in performance year 2020, clear definition must be referenced as to what would qualify to count toward the query. For example,

- Will a browser-based query qualify? Or will the query need to originate from a link or an API within CEHRT?

- If it is acceptable to query outside of CEHRT, the manual data entry of the query may not be calculable. What will the requirement be to capture the data within CEHRT?

- If the query will be required to originate within CEHRT, is there consideration for any IT backlogs from either the state entity, health systems, hospitals, physicians, and collaboration with their CEHRT vendors?

And finally, consideration must be made for the financial burden of the end-user, namely the physician medical practice. Lack of oversight of integration fees passed down from EHR vendor to practice has become problematic. Medical practices who have invested in CEHRT are at the mercy of the vendor as to what the vendor will charge to complete the integration, in addition to the ongoing maintenance fees. We request CMS to resolve the prohibitive financial burden placed on practices by the EHR vendor, who currently has the ability to charge

"carte blanche." These fees are debilitating and prohibitive to sustaining a medical practice. Until this is adequately addressed and remedied, burdens on practices are daunting and we will not support it.

Promoting Interoperability – Verify Opioid Treatment Agreement

We would like to express concern regarding the proposed Promoting Interoperability measure Verify Opioid Treatment Agreement. We believe that it would cause great burden on a clinician to attempt to locate an Opioid Treatment Agreement they themselves did not create. Despite the query of a Prescription Drug Monitoring Program (PDMP), the time it could take to locate such an agreement could place patients and clinicians at a great disadvantage.

A data collection measure has not been established for CEHRT, therefore this could take time for vendors to prepare. Short of every clinician participating in a health information exchange and able to consume a specific document coded for an Opioid Treatment Agreement, how would this data be captured? This is not a standard document. It is typically a manual document scanned into a patient record. How would the manual data be captured in CEHRT?

Rather than verifying an Opioid Treatment Agreement with at least 30 cumulative days within a six-month lookback period, we suggest modifying the measure to "Confirm Opioid Treatment Agreement on Record" prior to a patient beginning a treatment plan involving opioids.

Opt-In and Voluntary Reporting Low-Volume Thresholds

We support the Opt-In and Voluntary Reporting low-volume thresholds. We appreciate the recognition that some clinicians may have an interest in participation in the QPP that have participated in preceding incentive programs, such as Medicare EHR Incentive Program and PQRS, and have been excluded in Years 1 and 2.

We also support the expansion of the low-volume threshold to include a third criteria in order to opt-in, voluntarily report, or take an exclusion.

Remove Public Health and Clinical Data Exchange from the Promoting Interoperability Objectives

Lack of interoperability and integration back log has become problematic to practitioners to meet requirements for the Public Health and Clinical Data Exchange Objective. We ask CMS to remove this requirement from the list of objectives and enable clinicians to report the data in an effective way to benefit their practice and workflow.

To date, physicians have been expected to absorb the financial burden of interoperability costs. As previously mentioned, absence of regulation on integration and maintenance fees the vendor passes through to physicians makes interoperability challenging. Physicians who have devoted their practice to CEHRT are invested. EHR vendors have been afforded an opportunistic position and are assessing exorbitant connection fees plus ongoing maintenance fees to complete an integration with no oversight or protections afforded to physicians.

Qualifying Participants

We support the proposal to allow all Partial Qualifying Participants (QP) to determine, through an election process, whether or not to be subject to MIPS reporting requirements and payment adjustment. In order to reduce clinician burden, we agree if the Partial QP does not make any election, they will not be subject to the MIPS reporting requirements and payment adjustment.

Request for Information on Promoting Interoperability and Electronic Healthcare Information Exchange through Possible Revisions to the CMS Patient Health and Safety Requirements for Hospitals and Other Medicare and Medicaid Participating Providers and Suppliers

We support CMS' commitment to the use of certified health IT and interoperable EHR systems to effectively improve care provided by Medicare and Medicaid physicians by using electronic healthcare information exchange.

Through incentive programs like Medicare EHR Incentive Program and the QPP, we have seen the benefits of adoption of EHRs and electronic exchange of information. We see many benefits of promoting interoperability such as:

- Streamlining patient access through Blue Button 2.0
- Coordination of care
- Monitoring health care trends through the use of population health applications
- Identifying at-risk populations
- The ability to track quality improvement
- Improving patient outcomes
- Reducing cost by eliminating redundancies
- Effective communication during transitions of care

The requirement of the 21st Century Cures Act of 2016 that empowers HHS to take steps to advance the electronic exchange of health information and interoperability is concerning. We would like to offer feedback on behalf of physicians who have invested their time and finances by adopting the EHR into their daily practice.

It appears that, along with requirements for the further advancement of electronic exchange of information, physicians and hospitals are asked to invest in further upgrades to the CEHRT they have so carefully and methodically chosen to best service their needs.

CMS regulates hospitals and eligible professionals whom are provided incentives to adopt this technology. With those incentives, regulations are attached. It appears that missing from the equation are payers and EHR vendors – who are not covered entities.

As interoperability is promoted, and we hear more information about Administration Simplification and the HIPAA Transactions and Code Set, and the Trusted Exchange Framework and Common Agreement (TEFCA), requirements for the further advancement of the electronic exchange of information are on the move. Our fear is that physicians have not had a loud enough voice during these processes.

We request that regulation or oversight needs to be addressed to limit the financial burden of integration and maintenance fees. Oftentimes, physicians opt to utilize a browser because integrating a PDMP into CEHRT is too costly. This is only one example of the integration process. Physicians are tied to their CEHRT and to participate in these programs could require a significant financial lift. These fees can run between a few hundred dollars upwards of almost $100,000. There is a true lack of consistency.

With CMS' support of application programming interfaces (API) to aid in promoting interoperability, our apprehension is these fees will continue to increase and the only physicians who will be able to afford to comply with the standards are those practicing with larger health systems with more robust IT departments able to commit their time.

We ask for your consideration that, as HIPAA Transactions and Code Sets standards for Authorization request and Claims attachments are finalized, you also consider the downstream effect on physicians. Payers will now have to abandon the independent portal created in order to comply with HIPAA standards. How will this affect collaboration between patients, payers, and physicians if they have to adjust their focus to a new platform after investing resources in a platform developed to satisfy their requirements?

Promoting Interoperability to benefit patient health and safety using healthcare information exchange is key in order to protect our patient population. Our concern is that, with the technical requirements that come along with this advancement, it will be a hardship and burden on the physicians who offer care to our patients, and in the end, isn't the significance of enabling the technology to enhance the patient-physician relationship?

We, the undersigned organizations, appreciate your consideration of our requests in this comment letter:

Pennsylvania Medical Society
Keystone Chapter, American College of Surgeons
Metropolitan Philadelphia Chapter, American College of Surgeons
Pennsylvania Academy of Dermatology and Dermatologic Surgery
Pennsylvania Academy of Otolaryngology – Head and Neck Surgery
Pennsylvania Allergy and Asthma Association
Pennsylvania Chapter, American College of Cardiology
Pennsylvania Psychiatric Society
Pennsylvania Rheumatology Society
Pennsylvania Section, American College of Obstetricians & Gynecologists
Pennsylvania Society of Gastroenterology
Pennsylvania Society of Oncology & Hematology

Thank you for the opportunity to present our comments on this proposed rule.

Sincerely,

Theodore A. Christopher, MD, FACEP
President